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# DERMATILLOMANIA: A CASE OF EXCORIATION DISORDER

## DERMATİLLOMANİ: BİR EKSKORİYASYON BOZUKLUĞU OLGUSU

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### Abstract

Also known as excoriation disorder and skin-picking disorder, dermatillomania is a psychological condition that manifests as repetitive, compulsive skin picking. Repetitive skin picking extends to pulling, squeezing, scraping, lancing, and even biting both healthy and damaged skin from various parts of the body. Herein, we presented a female patient with excoriation disorder.

**Keywords:** Excoriation disorder, dermatillomania, skin-picking disorder

### Öz

*Ekskoriyasyon bozukluğu ve deri yolma bozukluğu olarak da bilinen dermatillomani, tekrarlayan, kompulsif deri yolma şeklinde ortaya çıkan psikolojik bir durumdur. Tekrarlayan deri yolma, hem sağlıklı hem de zarar görmüş cildi vücudun çeşitli yerlerinden çekmeye, sıkmaya, kazımaya, koparmaya ve hatta ısırma kadar uzanır. Burada, ekskoriyasyon bozukluğu olan bir kadın hastayı sunduk.*

**Anahtar Kelimeler:** Ekskoriyasyon bozukluğu, dermatillomani, deri yolma bozukluğu

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## 1. Introduction

Dermatillomania / skin-picking disorder / excoriation disorder (ED) is characterized by recurrent and excessive picking, scratching or rubbing of normal skin and it falls under the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) heading of obsessive compulsive and related disorders because of its genetic and symptomatic connection with obsessive-compulsive disorder (OCD) (American Psychiatric Association, 2013; Jafferany and Patel, 2019). ED, unlike OCD, is more common in women, and skin-picking occurs without intrusive thought. The selective serotonin reuptake inhibitors (SSRIs) and antipsychotics (APs) can be used in treatment, similar to those in the OCD (Ozen et al., 2019a; Ozen et al., 2019b). Herein, we presented a female patient with ED.

## 2. Case Presentation

M.S., 38 years old, single, unemployed, female patient. She was being followed up at different psychiatry outpatient clinics for 23 years with a diagnosis of OCD and for 14 years with a diagnosis of ED. She was using clomipramine 150 mg/day per oral (PO) for six months in another clinic. Her skin-picking symptoms were not taken under control with this treatment. She was evaluated as OCD plus ED according to DSM-5. Previously prescribed drugs used by the patient at the effective dose and time were aripiprazole, quetiapine, risperidone, fluoxetine. The patient complained of symptoms of ED more than his OCD-related symptoms. The first complaint was acne squeezing and hair picking (trichotillomania). Afterwards, she started to pick the hairs, the acnes and skins in her entire body, especially in the face and arm region (Figure 1). After a while, he started to pick the skins of people other than himself. He did not get enough benefit because he was inconsistent with the treatments he was given for this purpose. Various scales were applied to the patient: 27 (high probability of OCD with psychiatric examination) for the Maudsley Obsessive-Compulsive Inventory, 34 (severe depression) for the Beck Depression Inventory, 43 (major anxiety) for the Hamilton Anxiety Rating Scale, 53 (significant anxiety and depression) for Brief Psychiatric Rating Scale. The Hacettepe Personality Inventory indicated that the patient's social and personal adjustment was impaired (1. Personal Adjustment Sub-Scale: Self-Realization Score (low), Emotional Stability Score (low), Neurotic Trends (low), Psychotic Symptoms (low); 2. Social Compliance Sub-Scale: Family Relationship Score (low), Social Relationship Score (normal), Social Norms Score (normal), Antisocial Trend (normal)). The Symptom Checklist-90-Revised (SCL-90-R) revealed high general symptom index (1. Somatization, 2.25 high; 2. Anxiety, 1.2 high; 3. Obsession, 1.7 high; 4. Depression, 1.846 high; 5. Interpersonal Sensitivity, 1.55 high; 6. Psychotic Symptom 0.8; 7. Paranoid Symptom, 1.83 high; 8. Anger, 2.16 high; 9. Phobic Symptom, 0.285; 10. Additional Score, 1.428 high; 11. General Symptom Index, 1.53 high.). It was decided to re-arrange the treatment of the patient. The patient's initial baseline laboratory data at the time of admission were at normal ranges. The patient's

thyroid, renal, and liver function tests were within normal limits. A history of smoking, alcohol and substance abuse was not available. Her mother and sister had generalized anxiety disorder and her father has obsessive-compulsive personality pattern. The patient had gastric bypass surgery and suicide attempts. The patient was started on sertraline 50 mg/day PO, trifluoperazine 5 mg/day PO and clomipramine 150 mg/day PO was continued. The patients and their relatives were informed about the effects and possible side effects of the treatment. Sertraline dose was increased to 100 mg/day and clomipramine dose was increased to 225 mg/day because there was no symptomatic change in one month later; trifluoperazine 10 mg/day was continued. The patient was also referred to cognitive behavioral therapy. Two months later, her complaints were reported to have partially decreased, and the doses of the drugs were regulated as follows: sertraline 200 mg/day, clomipramine 225 mg/day, trifluoperazine 10 mg/day. At the sixth month of the treatment, she stated that she was able to control her skin picking behaviour. The informed consent was obtained from the patient for their knowledge's.



**Figure 1.** Skin-Pickings on Face and Arms

## 3. Discussion

Patients with ED may pick minor irregularities in the skin or leave skin lesions such as acne, calluses, scar or crust remaining from the previous skin-picking. It is reported that it is more common in women. However, this finding may also be related to more women's access to health care facilities for treatment (Jafferany and Patel, 2019). Additional diagnosis rates are high. Clinical studies show that 57-100% of patients with ED are accompanied by anxiety and depressive disorders (Aydin and Gulseren, 2014). In a study evaluating 60 patients with psychogenic ED, the rate of additional diagnosis for depressive disorder was 16.6%; lifetime prevalence rate was 33.3% (Odlaug and Grant, 2008). In a study conducted in Turkey, ED diagnosis of 31 patients were compared with 31 patients diagnosed with chronic urticaria. Major depressive disorder (58.1%) was the most common attachment to patients with psychogenic ED (Çalikuşu et al., 2002). Additional diagnoses for anxiety disorders (panic

disorder, agoraphobia, social and specific phobia, OCD, post-traumatic stress disorder and generalized anxiety disorder) were 41-65% and the lifetime prevalence rate was 56% (Aydin and Gulseren, 2014). In a study conducted in our country, it was found that 45.2% of patients with psychogenic skin trauma had OCD (Çalikuşu et al., 2002). Our patient was diagnosed with OCD prior to ED diagnosis. As mentioned above, in our patient, psychiatric symptoms other than ED were prominent and impaired the patient's functionality. Treatment of our patient was arranged according to various symptoms. SSRI, AP and tricyclic antidepressant were used together. As in the OCD, drug doses were increased. The patient's life was organized with cognitive behavioral therapy (Ozen et al., 2019b).

As a result, dermatillomains/ED can be as chronic, resistant to treatment as other disorders in the OCD spectrum, and may put the patients' daily lives in a difficult pattern. Co-use of cognitive behavioral therapy and drug combinations may give positive results.

*Patient informed consent: Informed consent was obtained.*

*Ethics committee approval: There is no need for ethics committee approval*

*Conflict of interest: There is no conflicts of interest to declare.*

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